OMA Section on General Surgery

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Attn. Ontario General Surgeons
From: General Surgery Section Executive
Date: October 18, 2018
Re: Position Statement on New Specialist Splinter Group

Dear Colleagues,

Many members of the OMA Section on General Surgery are aware of the new Ontario Specialist Association (OSA) and may wonder where we fit into all of this.

Your Section Executive is fully aware of this issue and has had direct communication with Dr. David Jacobs, a Toronto radiologist and former OMA Board member, who is heading up this new group. In addition, we've discussed this situation not only with OMA President Dr. Nadia Alam, but also with several other surgical Sections as well as Anesthesia and have shared our views and perspectives. **The Section Executive on General Surgery held a teleconference last week to discuss these matters and were unanimous that it would not join the new OSA with its current structure, governance and plans**.

Our interpretation of the situation is that the OSA was formed for the purpose of preserving the income levels of those very high earning specialties, whose fees are an obvious target for any reasonable, rational and fair approach to relativity. Relativity is now a target of the government - not just the OMA, and it would be reasonable to assume that rather than decades of almost meaningless micro adjustments, that larger adjustments will be made in the next few years instead. Of note, the government's relativity formula pegs radiologists as twice the Ministry's target, which is almost certainly a major reason why this group has been formed.

Dr. Jacobs' splinter group is explicit that Sections interested in joining the specialist coalition **must agree** that there be **no negative relativity** (*that is, no fees of specialties on the high end of relativity would ever be decreased to accommodate increases and relativity adjustments for undervalued specialties*) and that relativity will only be achieved by differential disbursement of **NEW money**. He described it as "a line in the sand" that will not be redrawn. In other words, their incomes will be preserved at their high rates, and ours would only slowly rise when and if the government gives us a raise. Dr. Jacobs was explicit in my discussions with him that his plan is to redistribute new money to make small Sections that currently have no voice in the OMA happier. He mentioned Cardiac, Vascular and Thoracics, who he considers grossly underpaid despite the fact that their annual incomes are substantially higher than General Surgeons (on average more than 100K higher). He feels General Surgery's correction would come later (years??).

One should also be aware that it is unlikely that there will be much new money. **Negotiations between the OMA and Ministry are not going well.** The final gov't offer in mediation was that fee cuts will remain, which currently total 6.7% per year. No increases in the next 2 years and then 1.4% in year 3 and 4 of the deal. The gov't also offered a one-time $715 million (approx. 6%) signing bonus, which is less than one year's claw back. In short, at the end of this 4-year deal, we would still be way behind where we were in 2012, if the government had their way. In other words, no growth in 10 years! Adjusted for inflation - a 20% drop! The OMA's counterproposal has asked for 2% per year and restoration of all cuts.

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OMA EXECUTIVE

Dr. Chris Vinden (Chair), Dr. Alice Wei (Vice Chair), Dr. Harshad Telang (Secretary), Dr. Kevin Lefebvre (Tariff Chair),
Dr. Tim Jackson (Member-at-Large), Dr. Jennifer Macmillan (Member-at-Large), Dr. Jeff Kolbasnik (OMA Past Section Chair)

Even if the OMA won its counterproposal, it would still take about 25 years to achieve relativity under the proposed rules of the new coalition, and we would likely not see anything for several years. This is basically unacceptable.

Staying under the umbrella of the OMA also has significant risks. Psychiatrists and family doctors seem to have a disproportionate voice, and many are more interested in equity than relativity, despite the fact that they are very different concepts. And the downside of arbitration is apparent, as the arbitrators had evidently insisted on an early resolution to the relativity issue within the negotiation framework. The arbiter felt that the issue was very complex to address in a timely fashion and the parties agreed to institute a "Rough Justice" solution combining the OMA's CANDI model (Comparison of Average Net Daily Income) and the government's RAANI model (Relativity Adjusted Annual Net Income) for the first two years of a four year agreement. They evidently wanted this out of the way early, before addressing other aspects of the negotiations. RAANI assigns General Surgery a value of 1.34 (i.e. overpaid by 34%). CANDI assigns General Surgery a value of 0.98 (i.e. underpaid by 2 percent). The rough justice average is 1.16 (i.e. overpaid by 16%). This has been a source of considerable angst for our Section Executive, and we have articulated our concerns to the OMA.

In response to this crisis and realizing that relativity (e.g. money) is the main issue, the OMA is proposing an alternative model for addressing relativity. Under this model, sections would have an opportunity to make submissions directly to the arbitrator. **We feel that we can make very rational, reasonable and evidence-based arguments for our position.**

While we have argued for years that the OMA's governance model is strongly tilted in favour of family doctors and would usually have looked enthusiastically upon a separate specialist association as a better way forward, we currently feel that the underlying philosophy of this new group that is championing this initiative is neither fair nor reasonable. As such, we have significant concerns about the current leadership of this new splinter group. **Our current unanimous position is to remain with the OMA**, though we have conveyed to them in the strongest terms that our loyalty is dependent on a fair and reasonable approach to relativity. CANDI needs to be either fixed or replaced, and any relativity system needs to have modifiers for risk, complexity and intensity. **However, if the new specialty coalition releases a fair and transparent system of governance and a better way of addressing relativity that is different from what has already been conveyed to us, we will be more than happy to take a closer look.**

We will be going into the OMA Special Council meeting this weekend in Toronto on October 21 to further discuss the relativity update and possibly this new matter. We will update you accordingly should any new details be revealed.

Regards,
Chris Vinden, Section Chair
OMA Section on General Surgery

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